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ABSTRACT

This report examines the health risks and related financial risks faced by America's elderly. Documentation of the elderly's increased financial risk is presented which is based on data from a case study of the elderly in Massachusetts and on an analysis of the elderly's out-of-pocket health care costs using data from the Health Care Financing Administration. After an executive summary of the report, chapter I provides an introduction to the health and financial risks faced by the elderly. Chapter II includes data on the growing numbers of elderly with increasing chronic care needs. The elderly's inaccessibility to quality care caused by the current emphasis on health care cost containment and the lack of available protection against rising health care costs are considered. Chapter III presents data on the elderly's increasing out-of-pocket costs. Chapter IV looks at those elderly persons at highest financial risk and documents the extent of financial risk associated with chronic illness. Chapter V calls for Congressional action to reduce the elderly's risk by limiting their out-of-pocket costs to 15 percent of income and by implementing a coherent policy for long-term care that will protect the elderly from impoverishment when faced with chronic illnesses. Appendices contain an analysis of elderly's out-of-pocket health care costs and a description of the Massachusetts study's methodology. (RNB)

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AMERICA'S ELDERLY AT RISK

A REPORT

PRESENTED BY

THE CHAIRMAN

OF THE

SELECT COMMITTEE ON AGING

HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

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EXECUTIVE SUMMARY

In America today, there are those who claim that the elderly are "well off" and can easily afford to absorb cutbacks in Social Security, Medicare and Medicaid. Nothing could be further from the truth. While in some ways the elderly are better off than they were 50 or even 20 years ago, they remain at great risk when it comes to paying for the health care they so desperately need.

Two studies of elderly health care costs sponsored by the House Select Committee on Aging clearly show the dilemma faced by the elderly. While everyone concedes that the Medicare program has long term financial problems, many people fail to recognize that the elderly also face great financial risk.

According to Committee estimates, America's aged will spend $1,660 in 1985 for health and long term care -- over 15 percent of their already limited incomes. This year is the first in which the elderly will spend more of their income on health care than they did when Medicare and Medicaid began. The situation will only get much worse over the next five years. The Committee projects that by 1990, elderly out-of-pocket spending will grow to $2,583 -- a whopping 18.9 percent of their income.

While these estimates speak to the "average elderly", a second analysis prepared at the request of the Chairman documents the frighteningly high financial risk facing those elderly with chronic and disabling illnesses such as Alzheimer's disease.

Based on surveys of elderly living in the community in Massachusetts, 63 percent of elderly persons aged 66 and older living alone will impoverish themselves after only 13 weeks in a nursing home. For married couples 66 years and older, one out of three (37 percent) will become impoverished within 13 weeks if one spouse requires nursing home care.

The financial risk of caring for an Alzheimer's victim at home is also high. Survey data show that one of six married couples (16 percent) aged 66 and older risk impoverishment after 13 weeks of home care, and nearly half (46 percent) face impoverishment after one year. The analysis of financial risk among the elderly in Massachusetts is illustrative of what is happening to the elderly across the country.

This situation is deplorable and demands the immediate attention of the Congress. The Congress should act to limit elderly out-of-pocket costs so they do not rise beyond the current level of 15 percent of income. The Congress should also take immediate steps to develop and implement a coherent long term care policy which protects America's aged from impoverishment due to chronic and disabling illness.

CHAPTER I
INTRODUCTION

America's elderly are at risk. Recent attempts to cast the elderly as "well-off" belie the fact that as a group, the elderly are more vulnerable to chronic, disabling diseases than their younger counterparts. This added health risk comes with a hefty price - rising out of pocket costs for health and long term care.

No sector of America's aged is totally immune from the health and financial consequences of catastrophic and chronic illness. For the unsuspecting elder struck with an illness such as Alzheimer's disease, the risk of impoverishment is real and extends further into the middle income levels than most of us care to realize.

The nature of the elderly's health risks and the reach of related financial risks across income levels is the subject of this report. Presented in the report is documentation of the elderly's increased financial risk based on new data from a case study of elderly in Massachusetts and on an analysis of the elderly's out-of-pocket costs using data from the Health Care Financing Administration. The statement these analyses make is clear -- the majority of America's elderly remain virtually unprotected against the devastating costs of chronic illness.

Health care is a major concern of the elderly. Not only are they more susceptible to health problems than any other group, but a proportionally larger percentage of their personal resources are spent obtaining the health care they need. And this proportion is growing. In 1985 the elderly will spend over 15 percent of their income on health care - an average of $1,660 per person. The Committee projects that from 1984 to 1990, the elderly's expenditures for health care will rise twice as fast as their income. By 1990, 18.9 percent of the elderly's income will be spent on health care, an average of $2,583 per person annually.

Adding to the elderly's risk is a system of care ill-suited to their needs. The elderly are plagued with chronic illnesses while our system of care is oriented toward acute illnesses. Furthermore, many elderly find themselves without the necessary social supports, either from family or the community, to deal with these chronic conditions. Also lacking is a financing system to protect the elderly against the high costs of long term care.

Rather than moving to correct these deficiencies, recent measures taken by the federal government to contain health care costs have resulted in cutbacks in Medicare and Medicaid. These cutbacks only add to the elderly's risk and threaten the quantity and quality of care they receive in all treatment settings: the hospital, the physician's office, the nursing home, the community, and the home.

In the chapters that follow, data will be presented that call for immediate action by Congress to reduce the elderly's health and financial risks and to improve the quality of their lives. Chapter II includes data on the growing numbers of elderly with increasing chronic care needs. Chapter III presents data on the elderly's rapidly increasing out-of-pocket costs. Chapter IV documents, for the first time, the reach of financial risk associated with chronic illness into higher income groups. The final chapter is a call for federal action to reduce the risks faced by our grandparents, our parents and ourselves.

CHAPTER II
THE ELDERLY AT RISK

The Numbers of Elderly Are Increasing

Greater numbers of Americans are enjoying longer lives. In 1960, 9.2 percent of the population was age 65 and over but by 1990, 12.7 percent of the total population will be in this group. By 2010, this will rise to 13.8 percent. In the year 2030, it is projected that 21 percent of the U.S. population will be age 65 and older - nearly double the 1990 estimate. In absolute numbers this means that there will be 31.5 million elderly in 1990, 39 million in 2010 and 64.5 million in 2030.

The population of elderly 75 years of age and older is growing faster than any other age group. Between 1990 and 2010, the number of people age 75 and over will go from 13.6 million to 18.8 million. By 2030, there will be a staggering number of people - 30 million - age 75 and above.

The price of reaching old age, however, is the risk of living with impaired health and of having to exhaust one's financial resources to obtain needed health care. Far too many of our elderly spend the end of their lives in poor health and without dignity because they impoverish themselves while trying to pay for their health care.

The Elderly Have Greater Health Care Needs

The magnitude of the health care problems of America's elderly cannot be overlooked. The elderly are at greater risk than their younger counterparts of chronic, debilitating conditions such as heart and circulatory diseases, diabetes, arthritis, dementias such as Alzheimer's disease, and strokes. (Table 1.) It is estimated that 86 percent of the elderly have some chronic condition, 47 percent of the elderly living in the community have limited activity due to chronic illnesses and 18 percent have limitations of major activities. Survey data has also shown that the proportion of people with multiple diseases increases with age. It is estimated that the noninstitutionalized elderly have an average of three chronic conditions and that this rises to five among the institutionalized elderly population.

TABLE 1
Prevalence of Selected Impairments - 1981
(per 1,000 persons)

	All Ages	65 +
Visual Impairments	40.4	136.6
Hearing Impairments	82.9	283.6
Arthritis	12.1	464.7
Orthopedic Impairments	81.8	128.2
Heart Conditions	76.4	277.0
Hypertensive Disease	113.4	378.6
Arteriosclerosis	15.1	97.0
Emphysema	9.3	42.9

Often continual long term care, either in an institution or at home, is necessary. This care is costly and can consume a substantial proportion of the elderly's resources, leaving them in financial jeopardy. A case in point is Alzheimer's disease which affects five to seven percent of the elderly between 60 and 80 years of age. Of those 80 years and older, an estimated 20 to 30 percent are afflicted with Alzheimer's or other dementias. This devastating disease, which affects the rich and poor alike, is an irreversible, steadily deteriorating condition that often requires years of costly nursing home care. In many cases, the same elderly who saw themselves as financially secure at age 60 or 65 find themselves in a financial crisis within months after paying the unexpected costs of long term care for such lengthy illnesses.

The Elderly's Access To Quality Care Is Being Threatened

The current emphasis on health care cost containment places an added burden on the elderly. Many elderly are being discharged from hospitals "sooner and sicker" than is medically appropriate. As a result, their need for home health and nursing home services is greater. The major catalyst behind this trend is the prospective payment (DRG) system adopted by Medicare to contain hospital costs by limiting the length of stay in the hospital. Since the adoption of this system and, especially, since Medicare began limiting DRG payments, home health care agencies and nursing homes have noted an increase in the severity of illness among the elderly needing their care.

Tragically, the elderly find themselves increasingly unable to get the long term care they need due to the lack of available nursing home beds and restrictions on the few public programs that cover this type of care. Even when the elderly are eligible for Medicare or Medicaid, the amount of services and level of care covered are often inadequate.

The result is that more sick elderly are in the community, left to care for themselves and being burdened with increasing levels of out-of-pocket costs. Often, they have no choice but to use more and more of what limited resources they have or go without the needed care.

The Elderly Have Little Protection Against Rising Health Care Costs

Not only are the elderly more vulnerable to ill health, they also face severe risks financially in obtaining health care. No segment of the elderly population is completely protected from these financial risks and often the results are catastrophic. Our current public and private insurance programs offer little, if any, coverage for long term care, with the exception of Medicaid. The existing insurance systems are designed primarily to cover hospital care for acute illness and do little to protect the elderly from the costs of chronic illness. The small amount of long term care that is covered is "short-term" long term care — limited recuperative care following an acute hospital episode.

As a result of higher risk of chronic illness and the limited support from public and private insurance programs, America's elderly are facing ever increasing financial risks. The following two chapters examine the issue of financial risk in greater depth. The next chapter takes the perspective of the "average elderly" and the problem of rapidly rising out-of-pocket health care costs. The subsequent chapter examines the special risks for those elderly who are in need of long term care and risk becoming impoverished as a consequence.

CHAPTER III
THE ELDERLY AT FINANCIAL RISK

According to an analysis conducted by the House Select Committee on Aging, the elderly's health care cost burden has increased substantially in the last five years. Measured as a percentage of income, the burden is now higher than when Medicare and Medicaid began nearly twenty years ago. Over the next five years, the proportion of their income devoted to health care will continue to increase rapidly. Between 1984 and 1990, the elderly's health care payments will rise at a rate almost twice as fast as their income.

The Elderly's Out-of-Pocket Costs Will Increase Substantially Between 1980 and 1990.

Elderly out-of-pocket health care costs in 1980 were $966. Since that time, these costs have risen rapidly to a 1985 level of about $1,660 per elderly person. Out-of-pocket costs will increase even more rapidly at least through 1990 when the average out-of-pocket health care cost will be $2,583 per elderly person. Elderly out-of-pocket costs in 1990 will be over two and one-half times higher than they were a decade earlier. (Figure 1.)

Elderly Out-of-pocket Costs Are A Higher Percentage Of Income Than When Medicare And Medicaid Began.

In terms of out-of-pocket health care costs, the Committee's study clearly shows that the elderly in 1985 are significantly worse off than the elderly were in 1977 and 1980. The elderly's health care costs grew from just over 12 percent of their income in both 1977 and 1980 to approximately 15 percent last year. In 1985, they will be spending just over 15 percent of their limited income -- more than when Medicare and Medicaid began.

Unfortunately, even greater problems loom in the future. The Committee projects that the portion of elderly income that goes for health care will balloon to 18.9 percent by 1990. (Figure 2.) Although Medicare and Medicaid are supposed to protect the recipients from financial disaster due to illnesses, the elderly at the end of this decade will be using substantially more of their income for health care than when Medicare and Medicaid were implemented.

Elderly Out-of-pocket Costs Will Rise Twice As Fast As Elderly Income.

During the period from 1977 to 1980, health care costs rose at a fairly high rate of 10.7 percent annually. The elderly's income grew at annual rate of 9.0 percent during those years and was almost able to keep pace with the growth in health care costs. In addition, the difference between the growth rates for elderly health care payments and income was less in that period than in later periods. Between 1980 and 1984, the elderly's health care costs grew at an annual rate of 12.1 percent while their income grew at the much slower rate of 8.1 percent.

From now until the end of the decade, the elderly's financial burden will grow even faster than in the 1977-1984 period. Over the period from 1984 to 1990, the elderly's health care payments will rise at a rate about twice as fast as their income. Specifically, the elderly's share of health care costs are estimated to climb at a rate of 9.1 percent while elderly income is expected to increase at an annual rate of only 4.6 percent. (Figure 3.)

High Elderly Out-of-pocket Costs Are A Consequence Of Inadequate Financing For Chronic Care.

The inadequacy of our financing system for long term care is a major cause of increased out-of-pocket costs. Nearly two-fifths (38 percent in 1990) of elderly health care costs will be paid by the elderly themselves. In 1990, the Committee estimates that 55 percent of nursing home costs will be paid out-of-pocket by the elderly, along with 52 percent of physician costs and 66 percent of the costs of drugs and other care, including home health care. This can be compared with the 15 percent of acute hospital care paid out of pocket by the elderly. (Figure 4.)

While Medicaid does pay for a substantial amount of long term institutional care, it is only for the poorest of the poor. In Massachusetts alone, an estimated 75 percent of nursing home beds are occupied by Medicaid patients. However, to become eligible for Medicaid, the recipients must be poor or must "spend down" by depleting most of their assets. That 75 percent of all nursing home patients in this one state are covered by Medicaid illustrates the urgent need for changes in health care coverage to guard against the elderly's economic devastation.

This spend down requirement poses severe economic hardships, especially for elders who have spouses in a nursing home but must continue to support themselves financially. Currently, as many as two thirds of nursing homes patients who enter as private paying patients subsequently deplete their resources and have to turn to Medicaid.

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Consequences For Elderly Of Medicare And Medicaid Budget Cuts And A Failure To Contain Health Care Costs

Four years worth of cutting Medicare and Medicaid and failing to contain health care costs has taken a devastating toll on the elderly's financial resources. Assuming that the elderly should be using no greater a percentage of their income than in 1980, program cuts and the failure to control health care costs have increased the elderly's out-of-pocket health care payments in 1984 by nearly $6.8 billion -- an added $242 per elderly person.

Every year that there continues to be a failure to control the elderly's share of health care costs, America's elderly will get deeper and deeper into trouble. Looking ahead to 1990, these policies will add $28.7 billion to the elderly's health care burden -- an additional $900 per elderly person. This will occur even without any further cuts in Medicare and Medicaid.

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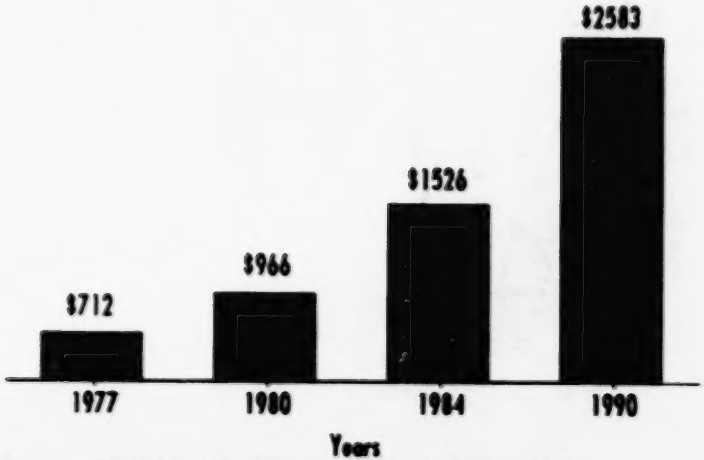
FIGURE I

Aged Per Capita Health Care Costs

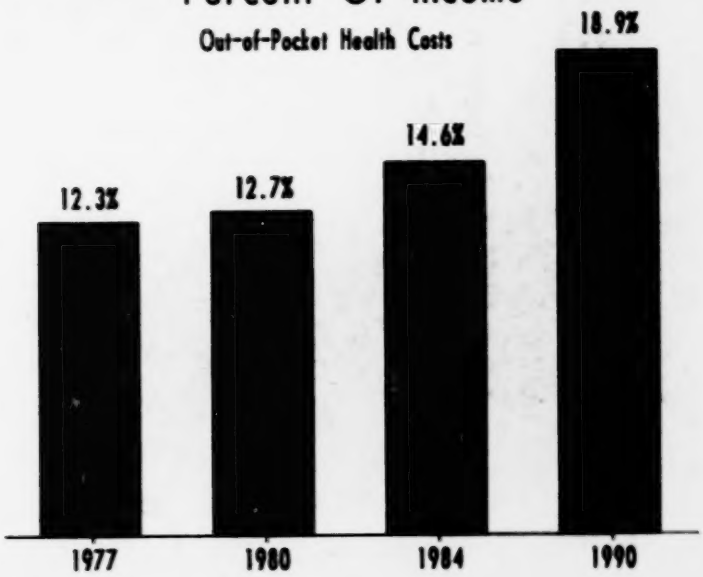
Out-of-Pocket Health Costs (in Dollars)



Source: House Select Committee on Aging, July 1985. Health Care Financing Administration, July 1985. Census Bureau, July 1985.

FIGURE 2

Aged Health Care Costs As Percent Of Income



Source: House Select Committee on Aging, July 1985. Health Care Financing Administration, July 1985. Census Bureau, July 1985.

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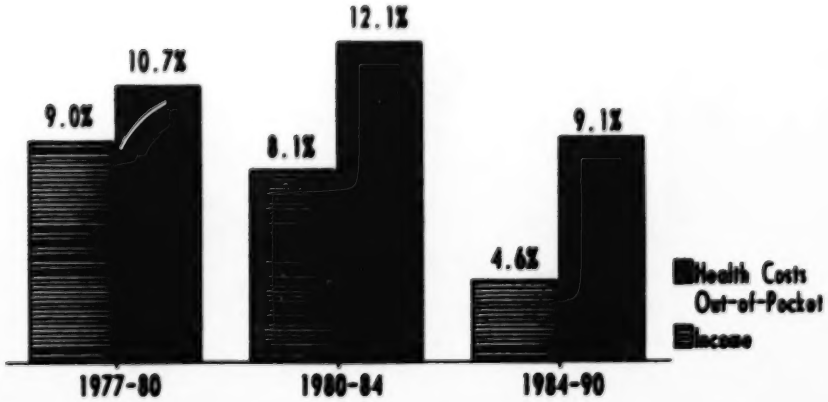
FIGURE 3

Aged Income and Health Cost Increases

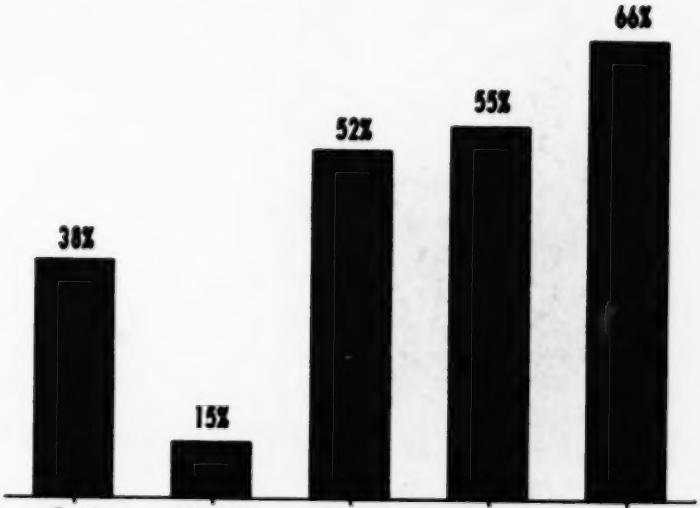
Annual Percent Increases



Source: House Select Committee on Aging, July 1985. Health Care Financing Administration, July 1985. Census Bureau, July 1985.

FIGURE 4

Percent of Health Care Costs To Be Paid By Aged In 1990



Source: House Select Committee on Aging, July 1988. Health Care Financing Administration, July 1988. Census Bureau, July 1988.

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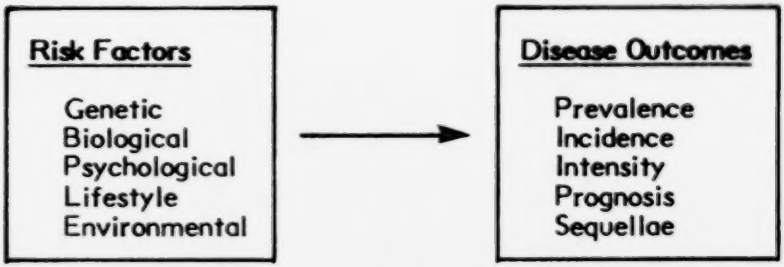
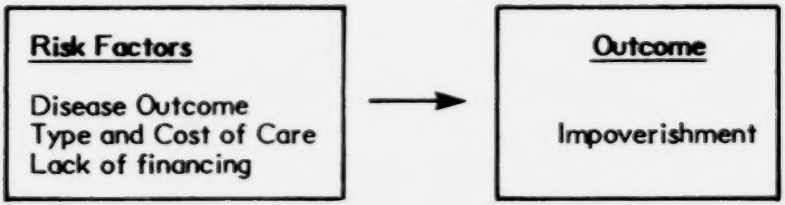
CHAPTER IV
THE ELDERLY AT HIGHEST FINANCIAL RISK

The Elderly at Greatest Health and Financial Risk

The elderly face two types of health risks. The first is the traditional biomedical model that describes specific health outcomes of diseases and conditions and the risk factors associated with those outcomes. Under this model, risk factors such as one's genetic, biological and psychological makeup as well as aspects of one's lifestyle and physical environment contribute to disease outcomes.



The second type of health risk is not biomedical but financial. The financial model of health risk reflects the risk of poverty following the onset of a chronic disease or a disabling condition. In the financial model, the risk factor is the disease or disabling condition itself and the risk is that of financial devastation resulting from costly health and long term care services.



It is this population of elderly - those with chronic illnesses requiring extended home or nursing home care - that are at highest risk physically and financially.

Using the example of institutionalization, regardless of cause, as a disease outcome under the biomedical model, we can specify some of the antecedent risk factors. These include advanced age, living alone, cognitive impairment, urinary incontinence, reliance on ambulatory aids, and the need for assistance with activities of daily living such as bathing, dressing, eating, housekeeping, grocery shopping, and food preparation.

We also can specify some of the parameters of this outcome. For example, prevalence rates for nursing home use by age are 1-2 percent for U.S. elders aged 65 to 74, five to six percent for those 75 to 84 years of age and approximately 22 percent for those aged 85 years and older. Furthermore, one in four of all people 65 years and older will enter a nursing home before their death.

These individuals typically fall into three categories of patients -- those who enter a nursing home for rehabilitation and will be discharged to their own home within three to six months; those who enter a home for terminal care and will die within six to twelve months, and those who remain in a nursing home indefinitely in a state of dependency.

Research on the elderly has not, however, focused sufficient attention on the financial outcomes for elders and their families of long term nursing home and home health care. A collaborative analysis undertaken by researchers at Harvard Medical School and Blue Cross and Blue Shield of Massachusetts gives us a glimpse of the financial model of health risk and the financial outcomes associated with nursing home and home health care. Their results are startling.

The Elderly in Massachusetts - A Study of Financial Risk

The Massachusetts analysis looks at the elderly's risk of impoverishment for one tragic and increasingly prevalent disease - Alzheimer's disease. Based on two surveys with a total of over 900 elderly Massachusetts residents living at home, the analysis examines the financial implications of home and nursing home care for victims of Alzheimer's disease and their spouses.

Traditional epidemiology tells us little about the antecedent risk factors associated with Alzheimer's disease. Risk factors such as advancing age, neurotransmitter deficiency and diet have been postulated, but consensus remains elusive. Our knowledge about the parameters of the disease outcome is no more advanced. Estimates of prevalence vary widely and suggest that five to seven percent of those age 60 to 65 may suffer from Alzheimer's disease to varying degrees, while as many as 20 to 30 percent of those over age 80 may be victims of Alzheimer's or other dementias.

While we eagerly await more information on the cause and treatment of Alzheimer's disease, we can begin to consider and work to reduce the risk of impoverishment this disease carries for its victims and their families as well as the implications of this risk for elderly persons with other chronic illnesses.

The logic of analyzing financial risk subsequent to nursing home care or home care for an Alzheimer's patient is simple. Each older person or couple has a certain amount of income and liquid assets. If an elderly person enters a nursing home or requires extended home care, one can calculate the number of weeks it will take before the individual's or the couple's income and liquid assets have been spent down to Medicaid eligibility levels based on estimated nursing home and home health costs.

For the purpose of the Massachusetts analysis, an elderly person was considered eligible for Medicaid only after their self-reported 1984 liquid assets had been spent down to $1,000 and only if their self-reported 1984 income was spent down to no more than $4,000 - a level well below national poverty guidelines. In the case of couples, joint liquid assets of no more than $3,000 and income of no more than $5,000 were used to approximate Medicaid eligibility. For the Alzheimer's victim and for the spouse who must remain in the community in an impoverished state, the emotional and financial consequences of "spend down" can be tragic.

How quickly do the elderly spend down their income and assets once dependent on in-home or nursing home care? In Massachusetts, the estimated 1984 statewide private pay rate charged most frequently in a skilled nursing facility was $75 a day -- that's over $27,000 annually. The approximate cost for caring for an Alzheimer's victim in the home in the advanced stages of the disease was estimated at $35.00 per day, or nearly $13,000 per year.

At these rates and in the absence of public or private insurance for long term care, it is not surprising that the majority of all nursing home residents are on Medicaid and that the time between financial independence and impoverishment is alarmingly short. The results of the Massachusetts analysis bear this out.

Study Results

The data on elderly income and assets used in the financial risk analysis were based on two recent collaborative statewide surveys in Massachusetts. One is the Harvard Medical School's Massachusetts Health Care Panel Study (HMS) which includes over 500 elderly persons over age 75 living in the community. The other survey, conducted by Blue Cross and Blue Shield of Massachusetts (BC/BS) in 1985, includes nearly 400 noninstitutionalized respondents aged 66 and older. (Refer to Appendix B for additional information.)

Table 2 and Figures 5 and 6 present the number of weeks it takes older people living in the communities of Massachusetts to become impoverished once institutionalized or once a regimen of home care has begun for a spouse with Alzheimer's disease.

The results are astonishing. Among the HMS sample of elders 75 years of age and older who live alone, approximately half (46 percent) run the risk of spending down to impoverishment after only 13 weeks of nursing home care. Only one of four people in this same sample would escape impoverishment in the first year following nursing home placement. Among the slightly younger (66 years and older) Blue Cross and Blue Shield sample, nearly two out of three elderly (63 percent) living alone are at risk of impoverishment by the 13th week of institutionalization.

If one spouse in a married household is placed in a nursing home, both the institutionalized person and the spouse run the joint risk of impoverishment at alarming rates. Among the older HMS respondents, approximately one of four households (25 percent) in which both spouses are aged 75 and older would become impoverished within 13 weeks. One out of three (37 percent) of all households aged 66 and older would become impoverished in the same time period. It is important to bear in mind that in these cases, all the subsequent health care costs of the spouse who remains in the community will likely become the financial responsibility of Medicaid.

The financial risks of caring for an Alzheimer's victim at home are also staggering. Among the HMS households with both spouses aged 75 years and older, one out of ten households (11 percent) risk impoverishment within 13 weeks, and two out of five (41 percent) within one year. Among the younger Blue Cross and Blue Shield sample, one of six married households (16 percent) risk impoverishment within 13 weeks and nearly half (47 percent) face impoverishment within one year.

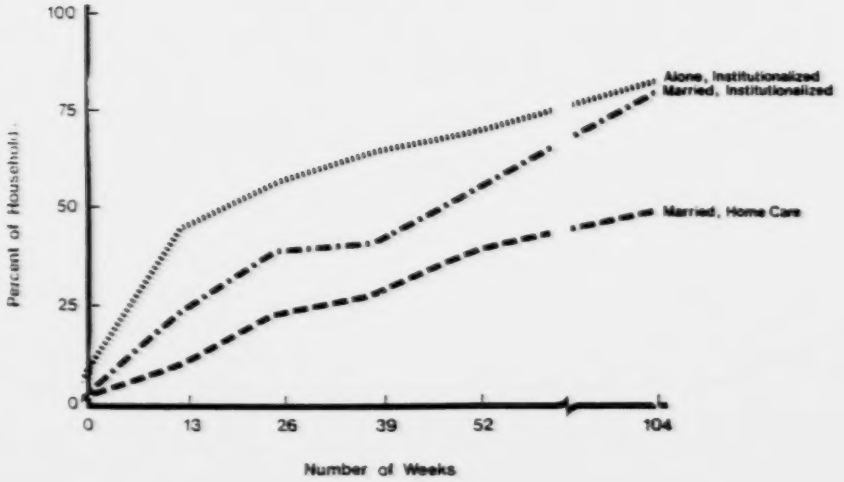
TABLE 2
PERCENT OF ELDERLY IMPOVERISHED
By Number Of Weeks

Sample	Number of Weeks 0	13	26	39	52	104
Pop. 75+ (HMS)						
Alone, In Institution	7%	46%	59%	66%	72%	85%
Married, In Institution	2%	25%	41%	43%	57%	82%
Married, At Home	2%	11%	25%	30%	41%	52%
Pop. 66+ (BC/BS)						
Alone, In Institution	8%	63%	74%	80%	83%	91%
Married, In Institution	4%	37%	47%	53%	57%	80%
Married, At Home	4%	16%	33%	39%	47%	55%

FIGURE 5

Number of Weeks Required for Massachusetts Elderly to Spend-Down Income and Assets to Approximate Medicaid Eligibility, 1984

Population Aged 75 + (HMS)



Sources: L.G. Branch, Massachusetts Health Care Panel Study, Wave IV, 1985.

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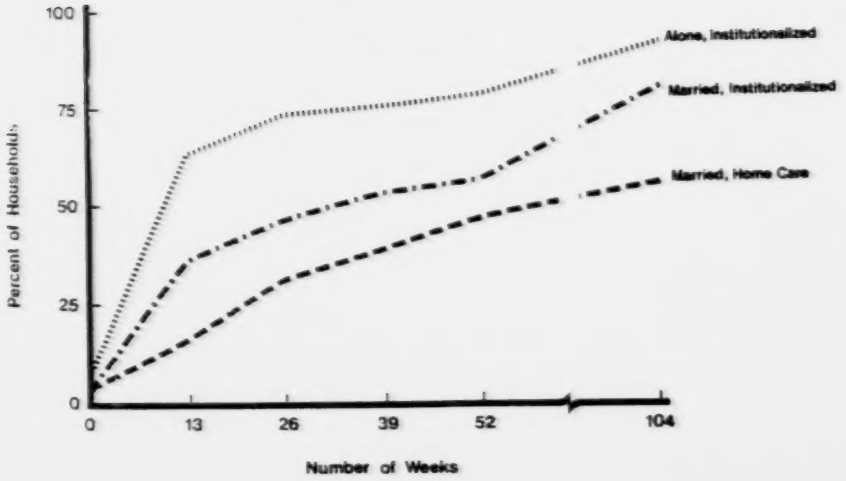
FIGURE 6

Number of Weeks Required for Massachusetts Elderly to Spend-Down Income and Assets to Approximate Medicaid Eligibility, 1984

Population Aged 66 + (BC/BS)



Sources: D.J. Friedman, E. Socholitzky, Blue Cross and Blue Shield of Massachusetts, 1985.

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The Implications

What are the implications of the alarming projections borne out by the Massachusetts data? First and foremost, the risk of becoming financially destitute following institutionalization or after paying for home care reaches further into the higher elderly income levels than most people expect. In this respect, the risk faced by elders in Massachusetts is a warning of the risk of elderly Americans nation-wide.

Is this finding inconsistent with the often-heard assertion that the vast majority of our country's elderly are economically well-off and in financial control of their own lives? Not at all. Statements about the economic well-being of our elders are mistakenly made only in the context of predictable costs and expenses and without giving full consideration to their reliance on fixed incomes. From the perspective of most elderly persons living alone or with a spouse, the daily rates for home care or nursing home care are unpredictable catastrophic expenses that far exceed their life savings.

How many older people are actually at risk of impoverishment? While we lack definitive data on the numbers of elderly at risk of extended in-home or nursing home care, the available data paint a bleak picture.

In 1984 - the focus years of the Massachusetts surveys - the total U.S. population aged 65 years and older was 28 million. Approximately five percent of these, 1.4 million people, were already in institutional settings and many of these (an estimated 75 percent in the case of Massachusetts) had already depleted their resources down to Medicaid levels. For each of these nursing home residents, it has been estimated that another one or two elderly share equal levels of dependency. That puts as many as 2.8 million elderly at immediate risk of costly nursing home care. In addition, an estimated one in four older Americans - 7 million people - will spend some time in a nursing home before the end of their lives. Based on current expenditures, approximately half of the cost of their care, over $12 billion annually, will be paid for out-of-pocket.

Another source of financial risk is the risk of Alzheimer's disease. For the vast majority of the victims of this disease, nursing home care and the associated costs are inevitable. Based on preliminary data on the prevalence of Alzheimer's disease, as many as five to seven percent or two million older Americans between 60 and 80 years of age are potentially at risk of needing costly home or nursing home care at some point in their lives for this disease alone. Beyond this group are countless others who will suffer from other debilitating diseases requiring constant care.

These estimates are conservative indicators of the potential numbers of elderly who may require long term care in the future. The data from the Massachusetts surveys indicate that the vast majority of the elderly in the highest category of health risk are also at high risk of impoverishment.

The message is clear. The likelihood of impoverishment is extremely high if an elderly person is placed in a nursing home or needs extensive home care on an prolonged basis. In aggregate, the likelihood of needing this type of care is less - but the risk of impoverishment is real for millions of unsuspecting middle and low income elderly.

Chronic illness does not discriminate by income level. For many Americans, the burden of chronic illness or caring for a loved one with a disabling disease such as Alzheimer's is made that much more difficult in the face of financial destitution.

One of these unfortunate Americans could easily be one of us.

CHAPTER V
REDUCING THE ELDERLY'S RISK — A CALL FOR FEDERAL ACTION

What should be done about the risk of health-related impoverishment? Reduce the risk.

In the traditional biomedical model, the individual is urged to modify risk factors such as one's diet and lifestyle to reduce the likelihood of disease.

In the model of financial risk, the individual has no real control. Only through political and administrative actions can these individuals be protected against the financial consequences of chronic disease.

The elderly's out-of-pocket expenses for health and long term care have risen substantially because of the failure of government to provide adequate protection. Because of inaction, more and more of the burden of this country's health care bill has been shifted to the most vulnerable of all Americans — the elderly and poor.

This trend cannot be allowed to continue. The elderly's out-of-pocket costs cannot be permitted to rise above already inflated levels. Nor should the elderly continue to go unprotected against the dire financial consequences of catastrophic and chronic illness.

In 1965, when Medicare and Medicaid were enacted, older Americans were led to believe that catastrophic health care costs would not lead to their impoverishment. In 1985, this risk still exists. While the Committee encourages other studies to further document the financial risk of elderly Americans across the country, Congress cannot afford to wait. The elderly's risk demands a call for federal action.

Toward this end, this Committee will work over the months ahead to see that the Congress acts to:

- Limit the elderly's out-of-pocket costs to no more than the current level of 15 percent of income, and

- Implement a coherent policy for long term care that will protect America's aged from impoverishment in the face of chronic and disabling illnesses.

APPENDIX A
ELDERLY OUT-OF-POCKET HEALTH CARE COSTS

Under the direction of Chairman Edward R. Roybal, the House Select Committee on Aging has completed an analysis of health care costs for America's aged in 1990. (Tables A-1 and A-2.) The key findings of the analysis are discussed in Chapter III, "The Elderly At Financial Risk," of this report.

Methodology And Data Sources For Estimating Elderly Out-of-pocket Health Care Costs.

Data sources for the analysis are primarily data and studies from the Health Care Financing Administration (HCFA). The two primary HCFA studies are "Demographic Characteristics And Health Care Use By The Aged In The United States: 1977-1984" (Fall, 1984) and "Health Spending Trends In The 1980's: Adjusting To Financial Incentives" (Summer, 1985). Medicare expenditure projections for 1985 through 1990 were also supplied by HCFA. Consumer price index projections are those used by HCFA as well. Population projections were provided by Bureau of the Census.

The projection model was developed by Committee staff and builds upon an adjusted HCFA estimate of health care costs for the elderly for 1984. Projections are made for each major component of health care expenditures (hospital, physician, nursing home, and other care) and for each source of payment (out-of-pocket, private insurance, Medicare premiums, other private, Medicare, Medicaid, and other government). The projections of each component are based on estimated population growth rates, price inflation and shifts in health care utilization.

TABLE A-1

PERSONAL HEALTH CARE EXPENDITURES
FOR PEOPLE AGED 65 AND OLDER
IN 1977, 1980, 1984 AND 1990

	PER CAPITA HEALTH EXPENDITURES			
	1977	1980	1984	1990
SOURCE OF FUNDS	$	$	$	$
Total	1,785	2,515	4,157	6,803
Private	719	976	1,543	2,608
Consumer	712	966	1,526	2,583
Out-of-Pocket	522	721	1,072	1,815
Insurance	115	148	308	535
Medicare Premiums	75	96	146	234
Other Private	7	10	17	24
Government	1,066	1,540	2,614	4,195
Medicare	713	1,061	1,832	3,036
Medicaid	249	333	543	835
Other Government	104	146	239	325

SOURCES: House Select Committee on Aging, July 1985; Census Bureau, July 1985; Health Care Financing Administration, July 1985

TABLE A-2

PERSONAL HEALTH CARE EXPENDITURES
AS A PERCENTAGE OF INCOME
FOR PEOPLE AGED 65 AND OLDER
IN 1977, 1980, 1984 AND 1990

ELDERLY CONSUMER COSTS AS PERCENTAGE OF INCOME	YEAR			
	1977	1980	1984	1990
% of Mean Income	12.30%	12.68%	14.62%	18.88%
% of Median Income	18.46%	18.53%	21.40%	-

SOURCES: House Select Committee on Aging, July 1985; Census Bureau, July 1985; Health Care Financing Administration, July 1985;

APPENDIX B

MASSACHUSETTS STUDY METHODOLOGY

Study Sample (Refer to Figure B-1)

The data on elderly income and assets used in the financial risk analysis were based on two recent collaborative statewide surveys in Massachusetts. The results of these surveys are presented in Chapter IV of this report, "The Elderly at Highest Financial Risk".

The first survey is the fourth in a series of interviews with Harvard Medical School's Massachusetts Health Care Panel Study. The panel began in 1975 with a statewide area probability sample of housing units. From this sample, 1,625 noninstitutionalized people aged 65 years and older were identified and agreed to participate in the study (79 percent of all those eligible). In 1985, 541 noninstitutionalized persons (aged 75 years and older by this time) were interviewed for the fourth time. Each was asked to provide 1984 income and liquid asset information as part of the interview. Among them, 200 lived alone and 88 lived in husband/wife households.

The second survey on which the financial risk analysis is based was conducted by Blue Cross and Blue Shield of Massachusetts in 1985. Based on a statewide area probability sample of housing units, 374 noninstitutionalized respondents aged 66 and older (75 percent of all those eligible) also provided 1984 income and liquid asset information. Respondents included 111 elders living alone and 98 husband and wife households.

Both the HMS and the Blue Cross/Blue Shield samples are representative of the elderly populations from which they were selected. However, the analytic samples of households selected for the specific analyses reported here are based on several limiting criteria including: household type (living alone or married and living only with spouse); age of both spouses (for HMS, both age 75 and over, for Blue Cross/Blue Shield, both age 66 and over); completion of interviews with both spouses; and provision of all requested income and assets data. The limiting criteria used for these analyses have affected sample sizes, and the results reported here should be regarded as suggestive rather than strickly representative of the Massachusetts population.

Cost Assumptions (Refer to Figure B-1)

Data on the costs of home-based care are difficult to derive. Based on a recent analysis, Alzheimer's patients require an average of 6.28 hours of homemaker or home health aide assistance per day (Hu, Huang and Cartwright, in press). In Massachusetts, the 1984 average wage and benefit rate for contracted homemaker/home health aide services is $5.69 per hour. The average daily home care costs for an Alzheimer's victim was therefore estimated at $35.00 (6.28 hours times $5.69 rounded down to nearest dollar).

Health and Economic Profile of Study Sample

A summary of the sociodemographic characteristics of the two households available for the Massachusetts analysis are presented in Table B-1.

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FIGURE B-1

SUMMARY OF STUDY SAMPLES
AND COST ASSUMPTIONS

SAMPLE DESCRIPTIONS

BC/BS: Blue Cross and Blue Shield of Massachusetts

- 1984 statewide area probability sample of housing units (non-institutionalized)
- Total sample size of 374 respondents in 1985
- Ages 66 and over in 1985

Subsample of households analyzed = 201

- Alone = 111
- Married (husband/wife only households, both 66 and over) = 49
- Other living arrangements = 41

HMS: Massachusetts Health Care Panel Study, Harvard Medical School

- 1975 statewide area probability sample of housing units (non-institutionalized)
- Total sample size of 541 respondents in 1985
- Ages 75 and over in 1985

Subsample of households analyzed = 352

- Alone = 200
- Married (husband/wife only households, both 75 and over) = 44
- Other living arrangements = 108

COST ASSUMPTIONS

Institutionalized Costs

- $75/day, based on estimated 1984 Massachusetts private day statewide most frequently charged Skilled Nursing Facility rate

Home Care Costs

- $35/day, based on 6.28 hours/day (Hu, Huang, and Cartwright, in press) at $5.69/hour (estimated 1984 Massachusetts average wage and benefit rate for contracted homemaker/home health aid services)

Poverty: Approximate 1984 Massachusetts Medicaid-only eligibility limits

- Alone = Assets spent-down to not more than $1000; income spent-down to not more than $4000;
- Married = Assets spent-down to not more than $3000; income spent-down to not more than $5000.

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TABLE B-1

SELECTED CHARACTERISTICS OF HOUSEHOLDS AVAILABLE FOR FINANCIAL RISK ANALYSIS

	66 + BC/BS		75 + HMS	
Household Composition				
Alone	55%	(111)	57%	(200)
With Spouse	24%	(49)	12%	(44)
Spouse & Others	2%	(5)	3%	(9)
Others Only	18%	(36)	28%	(99)
TOTAL	99%*	(201)	100%	(352)
Age				
66 to 74	51%	(102)	—	—
75 to 84	40%	(79)	75%	(264)
85 +	10%	(19)	25%	(88)
TOTAL	101%*	(200)	100%	(352)
Gender				
Female	58%	(117)	68%	(240)
Male	42%	(84)	32%	(112)
TOTAL	100%	(201)	100%	(352)

* Due to Rounding

TABLE B-1 (Continued)
Selected Characteristics
Households Available for Financial Risk Analysis

	66 + BC/BS		75 + HMS	
Home-Ownership				
Owns	42%	(83)	43%	(152)
Rents	56%	(109)	46%	(162)
Other	2%	(4)	11%	(38)
TOTAL	100%	(196)	100%	(352)
Self-Reported Income				
$5000 and Under	23%	(47)	28%	(98)
$6000 - $10,000	49%	(99)	50%	(175)
$11,000 - $15,000	13%	(26)	8%	(29)
$16,000 - $20,000	4%	(9)	8%	(29)
$21,000 and Over	10%	(20)	6%	(21)
TOTAL	99%*	(201)	100%	(352)
Self-Reported Assets				
$1000 or Under	36%	(73)	26%	(93)
$2000 - $10,000	35%	(70)	39%	(136)
$11,000 - $20,000	7%	(14)	9%	(30)
$21,000 - $50,000	8%	(16)	12%	(42)
$51,000 and Over	14%	(28)	14%	(51)
TOTAL	100%	(201)	100%	(352)

* Due to Rounding